CABINET FOR HEALTH AND FAMILY SERVICES
Office of Health Data and Analytics
Division of Health Benefit Exchange
(New Administrative Regulation)

900 KAR 10:115. Exchange participation requirements and certification of qualified health plans and qualified stand-alone dental plans.

RELATES TO: KRS Chapter 13B, Chapter 304, 304.9-020(1), 304.12-020, 304.14-120, 304.17-380, 304.17A-095, 304.17A-240-304.17A-245, 304.17A.515, 304.17A-590, 304.17C, 20 U.S.C. 36B, 42 U.S.C. 300gg-5, 18022, 18031, 18042, 18054, 18082, 45 C.F.R. 155.706,45 C.F.R. Part 153, 154.230, Parts 155, 156

STATUTORY AUTHORITY: KRS 194A.050(1)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Office of Health Data and Analytics, Division of Health Benefit Exchange has responsibility to administer the Kentucky Health Benefit Exchange. KRS 194A.050(1) requires the secretary of the cabinet to promulgate administrative regulations necessary to protect, develop, and maintain the health, personal dignity, integrity, and sufficiency of the individual citizens of the commonwealth; to operate the programs and fulfill the responsibilities vested in the cabinet; and to implement programs mandated by federal law. This administrative regulation establishes the policies and procedures relating to the certification of a qualified health plan or a qualified stand-alone dental plan to be offered on the Kentucky Health Benefit Exchange, pursuant to and in accordance with 42 U.S.C. 18031 and 45 C.F.R. Parts 155 and 156.

Section 1. Participation Standards for Issuers Offering a Qualified Health Plan. In order to participate on KHBE, an issuer offering a QHP shall:

(1) Hold a certificate of authority that would permit the issuer to offer a health benefit plan and be in good standing with the Kentucky DOI;

(2) Be authorized by the division to participate on the KHBE;

(3) By February 1 of each year, submit Form KHBE-C1, Issuer Participation Intent Form, a nonbinding notice of intent to participate on KHBE during the next calendar year;

(4) Enter into a participation agreement with the division;

(5) Offer KHBE certified QHPs in the individual exchange or SHOP;

(6) Comply with benefit design standards as defined in 45 C.F.R. 156.20;

(7) Provide coverage of the:

(a) Essential health benefits; or

(b) Essential health benefits excluding pediatric dental essential health benefits, if a stand-alone pediatric dental essential health benefit is offered on the KHBE in accordance with 45 C.F.R. 155.1065;

(8) Comply with applicable standards established in 45 C.F.R. Part 153;

(9) Not discriminate, with respect to a QHP, on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation;

(10) Comply with the non-discrimination requirements in 42 U.S.C. 300gg-5;

(11) Submit verification of issuer compliance with the requirements of 45 C.F.R. 156.340, including compliance of a delegated and downstream entity;

(12) Submit via SERFF:

(a) A quality improvement strategy plan in compliance with 45 C.F.R. 156.200(b)(5) and 45 C.F.R. 156.1130; and

(b) An attestation that the issuer shall comply with the quality requirements identified in 45 C.F.R. 156.200(b)(5) including:

1. Collection, disclosure, and report of information related to health care quality and outcomes in year two (2) of offering QHPs on the KHBE and annually thereafter; and

2. Implementation of an enrollee satisfaction survey in year two (2) of offering QHPs on the KHBE and annually thereafter;

(13) Comply with the provisions of 45 C.F.R. 156.210;

(14) For the individual exchange, offer at least a:

(a) QHP with a silver metal level of coverage;

(b) QHP with a gold metal level of coverage; and

(c) Child-only plan;

(15) For SHOP, offer at least a:

(a) QHP with a silver metal level of coverage; and

(b) QHP with a gold metal level of coverage;

(16) Make its provider directory for a QHP available:

(a) To a potential enrollee in hard copy upon request; and

(b) In accordance with 45 C.F.R. 156.230;

(17) If participating in the small group market, comply with KHBE processes, procedures, and requirements established in accordance with 45 C.F.R. 155.706 and 900 KAR 10:120 for the small group;

(18) Allow a registered participating agent to enroll qualified individuals on KHBE in accordance with the requirements of 900 KAR 10:125;

(19)(a) Offer a QHP in a statewide service area; or

(b) Offer a QHP in a service area less than statewide if:

1. The issuer's service area includes one (1) or more counties;

2. The issuer's service area is approved by the DOI; and

3. The issuer's service area is established in a nondiscriminatory manner with regard to:

a. Race;

b. Ethnicity;

c. Language;

d. Health status of an individual in a service area; or

e. A factor that excludes a high utilizing, high cost, or medically-underserved population;

(20) Comply with the requirements of KRS 304.12-020, 304.14-120, 304.17-380, 304.17A-095, 304.17A-240-304.17A-245, 304.17A.515, 304.17A-590, and KRS Chapter 304;

(21) Have the option to offer QHPs to include benefits in excess of the essential health benefits if the issuer also offers at least one (1) QHP on the exchange at the same metal level of coverage that is limited to the essential health benefits; and

(22) Have the option to offer a catastrophic plan on the individual exchange.

Section 2. QHP Rate and Benefit Information.

(1) A QHP issuer shall:

(a) Comply with the provisions of 45 C.F.R. 156.210 and KRS 304.17A-095;

(b) Submit to DOI through the SERFF system:

1. Form filings in compliance with KRS 304.14-120;

2. Rate filings in compliance with KRS 304.17A-095; and

3. Plan management data templates; and

(c) 1. Receive approval from DOI for a rate filing prior to implementation of the approved rate; and

2. For a rate increase that meets the criteria in 45 C.F.R. 154.230, post the justification prominently on the QHP issuer's Web site.

(2) A CO-OP, multi-state plan, and a qualified SADP shall comply with the requirements established in subsection (1) of this section.

(3) A QHP issuer shall comply with the maintenance of records standards pursuant to 45 C.F.R. 156.705.

(4) To be certified as a QHP, a health plan shall provide coverage of the:

(a) Essential health benefits; or

(b) Essential health benefits excluding pediatric dental benefits if there is at least one (1) SADP offered in each county through the KHBE.

Section 3. QHP Certification Timeframes.

(1) The division shall take final action on a request for certification no later than twenty-five (25) calendar days prior to the start of the annual open enrollment period for the following plan year.

(2) A QHP not certified by twenty-five (25) calendar days prior to the start of the annual open enrollment period shall not be offered on the KHBE at any time during the following calendar year.

Section 4. Transparency in Coverage.

(1) A QHP issuer shall provide the following information to the KHBE in accordance with the standards established in subsection (2) of this section:

(a) Data as identified in 45 C.F.R. 155.1050(a), 156.220, and 156.230;

(b) An SBC written in English for each CSR level in a QHP with the exception of zero cost sharing level for an Indian;

(c) An SBC written in Spanish for each CSR level in a QHP with the exception of zero cost sharing level for an Indian, with verification that the Spanish language version is a certified translation of the English version;

(d) If the plan includes a health reimbursement account, flexible spending account, or health savings account, a spending account fact sheet written in English for each CSR level in a QHP consistent with the requirements in KRS 304.12-020 and 806 KAR 12:010;

(e) If the plan includes a health reimbursement account, flexible spending account, or health savings account, a spending account fact sheet written in Spanish for each CSR level in a QHP with verification that the Spanish language version is a certified translation of the English version; and

(f) Information on patient responsibility for out-of-network coverage.

(2) A QHP issuer shall:

(a) Submit in an accurate and timely manner, to be determined by HHS, the information established in subsection (1)(a) and (f) of this section to the KHBE;

(b) Provide public access to the information established in subsection (1) of this section;

(c) Provide the items established in subsection (1)(b) and (d) of this section to KHBE within five (5) calendar days of the date DOI has approved rate and form filings in SERFF; and

(d) Provide the items established in subsection (1)(c) and (e) of this section to KHBE within fourteen (14) calendar days of the date KHBE has approved the items established in paragraph (c) of this subsection.

(3) A QHP issuer shall ensure that the information submitted under subsection (1) of this section is provided in plain language as the term is defined by 45 C.F.R. 155.20.

(4)(a) A QHP issuer shall make available, in a timely manner, information about the amount of enrollee cost sharing under the enrollee's plan or coverage relating to provision of a specific item or service by a participating provider upon the request of the enrollee.

(b) The information shall be made available to an enrollee through:

1. The internet; and

2. Other means if the enrollee does not have access to the internet.

(5) A QHP issuer may provide the following information to KHBE in accordance with the standards established by subsection (2) of this section:

(a) An SBC written in English for each zero cost sharing level for an Indian in a QHP; and

(b) An SBC written in Spanish for each zero cost sharing level for an Indian in a QHP, with verification that the Spanish language version is a certified translation of the English version.

Section 5. Marketing and Benefit Design of QHPs. A QHP issuer and its officials, employees, agents, and representatives shall:

(1) Comply with issuer marketing practices provided under KRS Chapter 304.17A and 806 KAR 12:010; and

(2) Not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with complex health care needs in QHPs.

Section 6. Network Adequacy Standards.

(1) A QHP issuer shall ensure that the provider network of a QHP:

(a) Is available to all enrollees within the QHP service area;

(b) Includes essential community providers in the QHP provider network in accordance with 45 C.F.R. 156.235 and meets the network adequacy standards for essential community providers as established in Section 7 of this administrative regulation;

(c) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be provided in a timely manner; and

(d)1. If a managed care plan, meets the reasonable network adequacy provisions of 45 C.F.R. 156.230 and KRS 304.17A-515; or

2. If not a managed care plan, meets the reasonable network adequacy provisions of 45 C.F.R. 156.230 and KRS 304.17A-515.

(2) A QHP issuer shall make its provider directory for a QHP available:

(a) To the KHBE for online publication;

(b) To potential enrollees in hard copy upon request; and

(c) In accordance with KRS 304.17A-590.

(3) A QHP issuer shall identify in the QHP provider directory a provider that is not accepting new patients.

Section 7. Network Adequacy Standards for Essential Community Providers. A QHP issuer shall:

(1)(a) Demonstrate a provider network, which includes at least the minimum percentage of available essential community providers in the QHP service area who participate in the issuer's provider network as required by 45 C.F.R. 156.235(a)(2)(i); and

(b) Offer a contract to:

1. At least one (1) essential community provider in each essential community provider category in each county in the service area where an essential community provider in that category is available; and

2. Available Indian health service providers in the service area; or

(2) If unable to comply with the requirements in subsection (1) of this section, submit a supplementary response via SERFF.

Section 8. Health Plan Notices. A QHP issuer shall provide notices to enrollees pursuant to standards established in 45 C.F.R. 155.230.

Section 9. Consistency of Premium Rates Inside and Outside the KHBE for the Same QHP. A QHP issuer shall charge the same premium rate without regard to whether the plan is offered:

(1) Through the KHBE;

(2) By an issuer outside the KHBE; or

(3) Through a participating agent.

Section 10. Enrollment Periods for Qualified Individuals.

(1) A QHP issuer participating in the individual market shall accept an enrollment during the open enrollment period or SEP for a qualified individual participating in the individual market with effective dates of coverage established by the division in accordance with 45 C.F.R. 155.410(f)(2) and 45 C.F.R. 155.420.

(2) A QHP issuer shall notify a qualified individual of the effective date of coverage.

(3) Except for renewal transactions prior to open enrollment, premium invoices shall be generated to a qualified individual within five (5) business days from receipt of KHBE enrollment transactions.

(4) A QHP issuer shall allow a qualified individual a minimum of thirty (30) days from the date of the initial invoice to submit premium payment before coverage can be cancelled.

(5) A QHP issuer shall allow a qualified individual a minimum of thirty (30) days from the date of a corrected invoice to submit premium payment before coverage can be terminated.

(6) Notwithstanding the requirements of this section, coverage shall not be effective until premium payment is received by the issuer.

(7) The issuer shall provide proof of coverage, including insurance identification cards, to enrollees within ten (10) calendar days of receipt of initial premium payment for ninety-nine (99) percent of enrollments.

Section 11. Enrollment Process for Qualified Individuals. A QHP issuer shall process enrollment of an individual in accordance with this section.

(1) A QHP issuer participating in the individual market shall enroll a qualified individual if the KHBE:

(a) Notifies the QHP issuer that the individual is a qualified individual; and

(b) Transmits information to the QHP issuer in accordance with 45 C.F.R. 155.400(a).

(2) If an applicant initiates enrollment directly with the QHP issuer for enrollment in a plan offered through the KHBE, the QHP issuer shall either:

(a) Direct the individual to file an application with the KHBE in accordance with 45 C.F.R. 155.310; or

(b) Ensure the applicant received an eligibility determination for coverage through the KHBE.

(3) A QHP issuer shall accept enrollment information in accordance with the privacy and security requirements pursuant to 45 C.F.R. 155.260 in an electronic format that meets the requirements pursuant to 45 C.F.R. 155.270.

(4) A QHP issuer shall follow the premium payment process in accordance with 45 C.F.R. 155.240.

(5) A QHP issuer shall provide new enrollees with an enrollment information package that complies with the accessibility and readability requirements established by 45 C.F.R. 155.230(b).

(6) A QHP issuer shall reconcile enrollment files with the KHBE no less than once a month in accordance with 45 C.F.R. 155.400(d).

(7) A QHP issuer shall acknowledge receipt of enrollment information transmitted from the KHBE in accordance with 45 C.F.R. 155.400(b)(2).

Section 12. Termination or Cancellation of Coverage for Qualified Individuals.

(1) A QHP issuer may terminate coverage of an enrollee in accordance with 45 C.F.R. 155.430(b)(2).

(2) If an enrollee's coverage in a QHP is terminated by the issuer, the QHP issuer shall:

(a) Provide the enrollee with a notice of termination of coverage that includes the reason for termination at least thirty (30) days prior to the final day of coverage, in accordance with the effective date established pursuant to 45 C.F.R. 155.430(d);

(b) If the termination is the result of death or termination by the issuer for non-payment of premium as established in subsections (3) through (8) of this section, provide the enrollee with a notice of termination of coverage within at least thirty (30) days of the action to terminate that includes the reason for termination, in accordance with the effective date established pursuant to 45 C.F.R. 155.430(d);

(c) Notify the KHBE of the termination effective date and reason for termination; and

(d) Comply with the requirements of KRS 304.17A-240 to 304.17A-245.

(3) Termination of coverage of enrollees due to non-payment of premium in accordance with 45 C.F.R. 155.430(b)(2)(ii) shall:

(a) Include the grace period for enrollees receiving APTC as established in 45 C.F.R. 156.270(d); and

(b) Be applied uniformly to enrollees in similar circumstances.

(4) Prior to termination of coverage, a QHP issuer shall provide a grace period of three (3) consecutive months if an enrollee receiving APTC has previously paid at least one (1) full month's premium during the benefit year.

(5) During the grace period, the QHP issuer:

(a)1. Shall pay claims for services provided to the enrollee in the first month of the grace period; and

2. May suspend payment of claims for services provided to the enrollee in the second and third months of the grace period;

(b) Shall notify the KHBE of the non-payment of the premium due; and

(c) Shall notify providers of the possibility for denied claims for services provided to an enrollee in the second and third months of the grace period.

(6) For the three (3) month grace period established in subsection (4) of this section, a QHP issuer shall:

(a) Continue to collect APTC on behalf of the enrollee from the U.S. Department of the Treasury; and

(b) Return APTC paid on behalf of the enrollee for the second and third months of the grace period if the enrollee exhausts the grace period as established in subsection (8) of this section.

(7) If an enrollee is delinquent on premium payment, the QHP issuer shall provide the enrollee with a notice of the payment delinquency.

(8) If an enrollee receiving APTC exhausts the three (3) month grace period in subsection (4) of this section without paying the outstanding premiums, the QHP issuer shall terminate the enrollee's coverage on the effective date of termination established in 45 C.F.R. 155.430(d)(4).

(9) A QHP issuer shall maintain records pursuant to 45 C.F.R. 155.430(c).

(10) A QHP issuer shall comply with the termination of coverage effective dates as established in 45 C.F.R. 155.430(d).

(11) A QHP issuer may cancel coverage of an enrollee in accordance with 45 C.F.R. 155.430(b)(2) and (e).

(12) If an enrollee's coverage in a QHP is cancelled by the issuer for any reason, the QHP issuer shall:

(a) Provide the enrollee with a notice of cancellation of coverage that includes the reason for cancellation within at least thirty (30) days of the action to cancel coverage, in accordance with the effective date established pursuant to 45 C.F.R. 155.430(d);

(b) Notify the KHBE of the cancellation effective date and reason for cancellation; and

(c) Comply with the requirements of KRS 304.17A-240 to 304.17A-245.

(13) Cancellation of coverage of enrollees due to non-payment of premium in accordance with 45 C.F.R. 155.430(b)(2)(ii) shall be applied uniformly to enrollees in similar circumstances.

(14) A QHP issuer shall comply with the cancellation of coverage effective dates as established in 45 C.F.R. 155.430(d).

(15) If coverage of an enrollee is terminated or cancelled by the KHBE for any reason, the QHP issuer shall provide the enrollee a notice of the termination or cancellation within fifteen (15) days of processing the termination or cancellation transaction from the KHBE or upon the expiration of the grace period, whichever occurs first.

Section 13. Accreditation of QHP Issuers.

(1) A QHP issuer shall:

(a) Be accredited on the basis of local performance of a QHP by an accrediting entity recognized by HHS in categories identified by 45 C.F.R. 156.275(a)(1); and

(b) Pursuant to 45 C.F.R. 156.275(a)(2), authorize the accrediting entity that accredits the QHP issuer to release to the KHBE and HHS:

1. A copy of the most recent accreditation survey; and

2. Accreditation survey-related information that HHS may require, including corrective action plans and summaries of findings.

(2) A QHP issuer shall be accredited prior to the fourth year of QHP certification and in every subsequent year of certification thereafter in accordance with the requirements and timeline identified under 45 C.F.R. 155.1045.

(3) A QHP issuer that has not received accreditation shall submit an attestation to the division that the issuer shall obtain accreditation in accordance with subsection (1)(a) of this section.

(4) The QHP issuer shall maintain accreditation so long as the QHP issuer offers QHPs.

Section 14. Decertification of QHPs.

(1) If a QHP is decertified by the division pursuant to 45 C.F.R. 155.1080 or withdrawn by the issuer after certification, the QHP issuer shall terminate coverage of enrollees only after:

(a) The KHBE has provided notification as required by 45 C.F.R. 155.1080(e);

(b) Enrollees have an opportunity to enroll in other coverage; and

(c) The QHP issuer has complied with the requirements of KRS 304.17A-240 to 304.17A-245, as applicable.

(2) If a QHP issuer fails to meet ongoing compliance requirements of Section 18 of this administrative regulation, the division may require the issuer to:

(a) Submit a corrective action plan to address deficiencies to ongoing compliance requirements within thirty (30) days of notification of the deficiency; and

(b) Submit evidence of compliance with the corrective action plan within the timeframes established in the division approved corrective plan.

(3) If the division finds that the QHP issuer failed to meet the requirements of subsection (2) of this section, the division may implement a prohibition against new enrollments on KHBE for the QHP issuer and market segment out of compliance or may decertify all plans offered by the QHP issuer within the market segment.

Section 15. General Requirements for a Stand-alone Dental Plan.

(1) In order for a dental insurer to participate in the KHBE and offer a stand-alone dental plan, the dental insurer shall:

(a) Hold a certificate of authority that would permit the issuer to offer dental plans and be in good standing with the DOI;

(b) Be authorized by the division to participate on the KHBE;

(c) By February 1 of each year, submit Form KHBE-C1, Issuer Participation Intent Form, a nonbinding notice of intent to participate on KHBE during the next calendar year;

(d) Enter into a participation agreement with the division;

(e) Offer a dental plan certified on the KHBE in accordance with this administrative regulation in the individual exchange or SHOP that shall comply with the requirements of KRS Chapter 304 Subtitle 17C;

(f) Submit to DOI through the SERFF system:

1. Form filings in compliance with KRS Chapter 304;

2. Rate filings in compliance with KRS 304.17-380; and

3. Dental plan management data templates;

(g) Offer a SADP that shall:

1. Provide the pediatric dental essential health benefits required by 42 U.S.C. 18022(b)(1)(J) for individuals up to twenty-one (21) years of age; and

2. Have an annual limitation on cost sharing for a SADP covering the pediatric dental essential health benefits at or below the limits permitted by 45 C.F.R. 156.150;

(h) Comply with the:

1. Provider network adequacy requirements identified by KRS 304.17C-040 and maintain a network that is sufficient in number and types of dental providers to assure that all dental services will be accessible without unreasonable delay in accordance with 45 C.F.R. 156.230;

2. Requirements for a SADP referenced in 45 C.F.R. 156 Subpart E; and

3. Essential community provider requirements in 45 C.F.R. 156.235;

(i) Not discriminate, with respect to a pediatric dental plan, on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation; and

(j) Make its provider directory for a SADP available:

1. To the KHBE for online publication;

2. To potential enrollees in hard copy upon request; and

3. In accordance with KRS 304.17A-590.

(2) A dental insurer offering a stand-alone dental plan participating in the KHBE shall provide the following information to the division on the KHBE:

(a) Statement of dental coverage that is:

1. Written in English consistent with the requirements in KRS 304.12-020 and 806 KAR 12:010; and

2. Submitted within five (5) calendar days of the date DOI has approved rate and form filings in SERFF; and

(b) Statement of dental coverage that is:

1. Written in Spanish with verification that the Spanish language version is a certified translation of the English version; and

2. Submitted within fourteen (14) calendar days of the date KHBE has approved the item described in paragraph (a) of this subsection.

Section 16. Enforcement by DOI. The DOI shall be responsible for enforcing the requirements of KRS Chapter 304 and any administrative regulations promulgated thereunder against any issuer.

Section 17. Timeframes for Transactions.

(1) A QHP issuer shall generate a required acknowledgement and process all KHBE initiated transactions within forty-eight (48) hours of receipt of a complete electronic transaction from the KHBE for ninety-five (95) percent of enrollments.

(2) A QHP issuer shall provide effectuation transactions to the KHBE within seventy-two (72) hours of receipt of the initial premium payment and issuer initiated cancellation and termination transactions within forty-eight (48) hours of the cancellation or termination of coverage for ninety-five (95) percent of cancellations and terminations.

Section 18. On-going Compliance. The division shall be responsible for enforcing the requirements referenced in 45 C.F.R. 155.1010(a)(2).

Section 19. Issuer Appeals.

(1) An issuer may appeal the division’s decision to:

(a) Deny certification of a QHP;

(b) Implement a prohibition against new enrollments by a QHP issuer in a market segment; or

(c) Decertify a QHP.

(2) An issuer appeal identified in subsection (1) of this section shall be made to the division in accordance with KRS Chapter 13B.

Section 20. Incorporation by Reference.

(1) Form KHBE-C1, “Issuer Participation Intent Form", Rev. March, 2021, is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Division of Health Benefit Exchange, 275 East Main Street 4WE, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m., or at www.khbe.ky.gov.

ROBERT PUTT, Executive Director
ERIC FRIEDLANDER, Secretary

APPROVED BY AGENCY: March 12, 2021

FILED WITH LRC: March 15, 2021 at 8:00 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on May 24, 2021, at 9:00 a.m. using the CHFS Office of Legislative and Regulatory Affairs Zoom meeting room. The Zoom invitation will be emailed to each requestor the week prior to the scheduled hearing. Individuals interested in attending this virtual hearing shall notify this agency in writing by May 17, 2021, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who attends virtually will be given an opportunity to comment on the proposed administrative regu-

lation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on this proposed administrative regulation until May 31, 2021. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to the contact person. Pursuant to KRS 13A.280(8), copies of the statement of consideration and, if applicable, the amended after comments version of the administrative regulation shall be made available upon request.

CONTACT PERSON: Krista Quarles, Policy Advisor, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, Kentucky 40621, phone 502-564-6746, fax 502-564-7091, email CHFSregs@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Persons: Melea Rivera and Krista Quarles

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the policies and procedures relating to the certification of a qualified health plan or a qualified stand-alone dental plan to be offered on the Kentucky Health Benefit Exchange

(b) The necessity of this administrative regulation: This administrative regulation is necessary to inform issuers of the requirements for certification of a health plan as a qualified health plan or certification of a dental plan as a qualified dental plan to be offered on the Kentucky Health Benefit Exchange.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation is necessary so that issuers are aware of the requirements for certification of a health plan as a qualified health plan or dental plan as a stand-alone dental plan to be offered on the Kentucky Health Benefit Exchange as required by 42 U.S.C. 18022, 18031, 18042, 18054, 45 C.F.R. Parts 155, 156.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation provides detailed requirements for certification of a health plan as a qualified health plan or certification of a dental plan as a qualified dental plan to be offered on the Kentucky Health Benefit Exchange to comply with the statute

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: This is a new administrative regulation

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: This administrative regulation will affect approximately 10 issuers that may request certification of a health plan as a qualified health plan or certification of a dental plan as a stand-alone dental plan to be offered on the Kentucky Health Benefit Exchange

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Each entity will submit information electronically through the SERFF system related to rate and form filings to the DOI for review by DOI and KHBE.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): $1,000.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): This administrative regulation will benefit each issuer that may request certification of a health plan as a qualified health plan or certification of a dental plan as a stand-alone dental plan to be offered on the Kentucky Health Benefit Exchange by providing detailed instructions regarding certification of Qualified Health Plans.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: The estimated cost to implement a state-based exchange will be $5,000,000 to the state but will result in significant savings to Kentuckians through reductions in health insurance premiums.

(b) On a continuing basis: The estimated cost will be $2,000,000 annually.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The source of funding to be used for the implementation and enforcement of this administrative regulation will be from Division of Health Benefit Exchange existing budget. No new funding will be needed to implement the provisions of this regulation.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in fees or funding is necessary.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish any fees and does not increase any fees either directly or indirectly.

(9) Tiering: Is tiering applied? Tiering was not appropriate in this administrative regulation because the administration regulation applies equally to all individuals and entities regulated by it.

FEDERAL MANDATE ANALYSIS COMPARISON

1. .Federal statute or regulation constituting the federal mandate. 20 U.S.C. 36B, 42 U.S.C. 300gg-5, 18022, 18031, 18042, 18054, 18082, 45 C.F.R. 155.706,45 C.F.R. Part 153, 154.230, Parts 155, 156.

2. State compliance standards. KRS 194A.050(1) requires the secretary of the cabinet to promulgate administrative regulations necessary to protect, develop, and maintain the health, personal dignity, integrity, and sufficiency of the individual citizens of the Commonwealth; to operate the programs and fulfill the responsibilities vested in the cabinet, and to implement programs mandated by federal law or to qualify for the receipt of federal funds. This administrative regulation establishes the policies and procedures relating to the certification of a qualified health plan to be offered on the Kentucky Health Benefit Exchange, pursuant to, and in accordance with 42 U.S.C. Section 18031 and 45 C.F.R. Parts 155 and 156.

3. Minimum or uniform standards contained in the federal mandate. The Affordable Care Act establishes the creation of the American Health Benefit Exchange as identified in Section 1311(a) of the Affordable Care Act. The “Kentucky Health Benefit Exchange” (KHBE) is the Kentucky state-based exchange conditionally approved by HHS established by 45 C.F.R. 155.105 to offer a QHP in Kentucky. An Exchange must make qualified health plans available to qualified individuals and qualified employers. At a minimum, an Exchange must implement

procedures for the certification, recertification, and decertification of health plans as qualified health plans. The Affordable Care Act allows for Exchanges to certify health plans as qualified health plans. This certification may be done if: The health plan meets the rules for certification by the U. S. Department of Health and Human Services; and The Exchange determines that making such health plan available through the Exchange is in the interests of qualified individuals and qualified employers in the state or states in which the Exchange operates. The Exchange must require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. These plans must prominently post such information on their websites.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. This administrative regulation does not impose stricter requirements than those required by the federal mandate

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? This administrative regulation affects the Office of Health Data and Analytics, Division of Health Benefit Exchange within the Cabinet for Health and Family Services and the DOI within the Public Protection and Regulation Cabinet.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. 20 U.S.C. 36B, 42 U.S.C. 300gg-5, 18022, 18031, 18042, 18054, 18082, 45 C.F.R. 155.706,45 C.F.R. Part 153, 154.230, Parts 155, 156.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? This administrative regulation will not generate any revenue.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This administrative regulation will not generate any revenue.

(c) How much will it cost to administer this program for the first year? Approximately $2,000,000.

(d) How much will it cost to administer this program for subsequent years? Approximately $2,000,000.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-): $2,000,000

Other Explanation: